

MOSQUITOBORNE ENCEPHALITIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 51382 (R/4-04)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill in circles like this: ☐ Not like this: ☒ Mark mistakes like this: ☒
- 4 Print capital letters only and numbers completely inside boxes. A 2 C 3
- 5 Please complete all items on form.
- 6 Date format: MM/DD/YY

Section 1. Demographic Information

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>		
Last Name		
<div style="border-bottom: 1px solid black; height: 1.2em; width: 45%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 5%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 50%;"></div>
First Name	MI	Phone Number
<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>		
Number & Street Address		
<div style="border-bottom: 1px solid black; height: 1.2em; width: 45%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 10%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 45%;"></div>
City	State	ZIP Code
<div style="border-bottom: 1px solid black; height: 1.2em; width: 45%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 10%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 45%;"></div>
County	Date of Birth	Age
Race: <input type="radio"/> Asian <input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> Other/Multiracial <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Unknown <input type="radio"/> Native Hawaiian or Other Pacific Islander		
Ethnicity: <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Unknown		
Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		
Is Age in day/mo/yr? <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years		
<div style="border-bottom: 1px solid black; height: 1.2em; width: 45%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 5%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 50%;"></div>
Occupation	Phone of Employer/School/Day Care	
<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>		
Name of <input type="radio"/> Employer <input type="radio"/> School <input type="radio"/> Day Care		
<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>		
Address of Employer/School/Day Care		
<div style="border-bottom: 1px solid black; height: 1.2em; width: 45%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 10%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 45%;"></div>
City	State	ZIP Code

Section 2. Clinical Information

Symptoms (check all that apply):		Method of Testing Used:
<input type="radio"/> Fever <div style="border-bottom: 1px solid black; width: 40px; display: inline-block;"></div> (degrees)	<div style="border-bottom: 1px solid black; width: 100px; display: inline-block;"></div>	<input type="radio"/> Culture
<input type="radio"/> Headache	Date of Onset	<div style="border-bottom: 1px solid black; width: 100px; display: inline-block;"></div>
<input type="radio"/> Dizziness		Specimen
<input type="radio"/> Myalgia	<div style="border-bottom: 1px solid black; width: 100px; display: inline-block;"></div>	Results: <input type="radio"/> Positive <input type="radio"/> Negative
<input type="radio"/> Fatigue	Duration of Symptoms in Days	<input type="radio"/> PCR
<input type="radio"/> Paralysis		<div style="border-bottom: 1px solid black; width: 100px; display: inline-block;"></div>
<input type="radio"/> Rash	<div style="border-bottom: 1px solid black; width: 100px; display: inline-block;"></div>	Specimen
<input type="radio"/> Neck Stiffness	Date First Positive Specimen Collected	Results: <input type="radio"/> Positive <input type="radio"/> Negative
<input type="radio"/> Stupor		<input type="radio"/> CSF
<input type="radio"/> Disorientation	Acute Flaccid Paralysis?	<input type="radio"/> Serology
<input type="radio"/> Tremors	<input type="radio"/> Yes	See page 2.
<input type="radio"/> Muscle Weakness	<input type="radio"/> No	
<input type="radio"/> Convulsions		
<input type="radio"/> Other, specify: <div style="border-bottom: 1px solid black; width: 100px; display: inline-block;"></div>		

MOSQUITOBORNE ENCEPHALITIS CASE INVESTIGATION - Page 2 of 4

Indiana State Department of Health
State Form 51382 (R/4-04)

Section 2. Clinical Information (continued)

1. IgM Testing

____/____/____
Acute Specimen Taken

Acute Value

____/____/____
Convalescent Specimen Taken

Convalescent Value

Results:

- ☐ Significant Rise in IgM ☐ Pending
☐ No Significant Rise in IgM ☐ Not Done
☐ Indeterminate ☐ Unknown

2. IgG Testing

____/____/____
Acute Specimen Taken

Acute Value

____/____/____
Convalescent Specimen Taken

Convalescent Value

Results:

- ☐ Significant Rise in IgG ☐ Pending
☐ No Significant Rise in IgG ☐ Not Done
☐ Indeterminate ☐ Unknown

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City State ZIP Code

Physician/Hospital Phone

Was the patient hospitalized before or during infection?

- ☐ Yes ☐ No

If Yes, admission date: ____/____/____

Discharge date: ____/____/____

Hospital: _____

Did patient die?

- ☐ Yes ☐ No

Diagnosis:

- ☐ Encephalitis ☐ Meningitis
☐ Uncomplicated fever ☐ Asymptomatic infection
☐ Other clinical ☐ Unknown

1. Did patient receive blood or blood product within previous 30 days? ☐ Yes ☐ No

2. Did patient donate blood or blood product within previous 30 days? ☐ Yes ☐ No

3. Is the patient a Presumptive Viremic donor? ☐ Yes ☐ No ____/____/____
If Yes, donation date

4. Was patient an organ recipient or donor within previous 30 days? ☐ Yes ☐ No

5. Is patient pregnant? ☐ Yes ☐ No

6. Was the patient breast-feeding at the time of the illness? ☐ Yes ☐ No

MOSQUITOBORNE ENCEPHALITIS CASE INVESTIGATION - Page 3 of 4

Indiana State Department of Health
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Section 3. Risk Factors

Patient's home setting:

☐ Urban ☐ Suburban ☐ Rural

Is the patient's home located adjacent to (check all that apply):

☐ Wetlands ☐ Woods ☐ Marsh/Bog ☐ Dumps
☐ Streams ☐ Ponds ☐ Sewage/Septic Effluent ☐ Other Area(s) of Standing Water

Are any of the following water containers located outside of the home or area (check all that apply)?

☐ Birdbaths ☐ Fountains ☐ Used Tires
☐ Garden Ponds ☐ Pools

☐ Other Containers, specify: _____

Does home have working screens for windows and doors?

☐ Yes ☐ No

During the two weeks prior to symptoms, did the patient:

Engage in outdoor activities at home?

☐ Yes ☐ No

If Yes, describe

____ / ____ / ____

Date

Engage in the following activities (check all that apply)?

☐ Camping ☐ Hiking ☐ Fishing ☐ Picnicking

If so, where

____ / ____ / ____

Date

Travel to recreational areas within county of residence?

☐ Yes ☐ No

If Yes, where

____ / ____ / ____

Date:

Travel outside of county of residence but within Indiana?

☐ Yes ☐ No

If Yes, where

____ / ____ / ____

Date

Travel outside of Indiana?

☐ Yes ☐ No

If Yes, where

____ / ____ / ____

Date

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☐ Yes ☐ No

_____ / _____ / _____

☐ Yes ☐ No

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Eastern Equine Encephalitis	<input type="radio"/> Suspect	<input type="radio"/> Probable	<input type="radio"/> Confirmed
St. Louis Encephalitis	<input type="radio"/> Suspect	<input type="radio"/> Probable	<input type="radio"/> Confirmed
La Crosse Encephalitis	<input type="radio"/> Suspect	<input type="radio"/> Probable	<input type="radio"/> Confirmed
West Nile Encephalitis	<input type="radio"/> Suspect	<input type="radio"/> Probable	<input type="radio"/> Confirmed
Other	<input type="radio"/> Suspect	<input type="radio"/> Probable	<input type="radio"/> Confirmed

[illegible]

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Date